City of Seattle—Retirees 65 and Over

2007 Benefit Summary

NOTE: You can receive additional Medicare information for 2007 by looking at: www.medicare.gov on the web, or by calling 1-800-633-4227.

Plan Features	Original Medicare Part A & B 2007	2007 Group Health (Standard & Deductible Plans) Medicare Advantage*	2007 Secure Horizons (PacifiCare) HMO Washington – Tier 1, Plan C	2007 Secure Horizons Direct Plan
Deductible	$131 deductible	$0 deductible	$0 deductible	$0 deductible
Out Of Pocket Limitations				
Out of Pocket Limitations	Varies dependent on service	Limited to a maximum of $1,000 per member per calendar year	$2,000	$3,960
Hospitalization				
Semiprivate room and board, general nursing and other hospital services and supplies	First 60 days, all but $992 61st to 90th day, all but $248 a day, 91st to 150th day, all but $496 a day (see booklet regarding one time use of up to 60 reserve days). Beyond 150 days, $0 is paid. Psychiatric Inpatient Care has a 190-day lifetime maximum.	$100 copay per day up to a 3-day maximum per member, per admission.	100% after $200 copay, per admission	100% after $220 copay, 1-18 days: $0 copay thereafter
Skilled Nursing Facility Care				
Semiprivate room and board, skilled nursing and rehabilitation services and other services and supplies	First 20 days, 100% of approved amount. Additional 80 days, all but $124 a day. Beyond 100 days, $0 is paid.	Covered up to 100 days per year, subject to Medicare guidelines and GHC approval. Must be in Medicare Certified facility.	$0 copay days 1-20, $50 copay per day, days 21-100 up to 100 days per benefit period.	$110 copay per day, days 1-36 days: $0 copay days 21-100 up to 100 days per benefit period.
Physician				
Physician care in hospital, home, office and most outpatient ancillary services	80% of approved amount subject to $131 deductible	In hospital visits covered at 100%. Outpatient visits covered in full after $15 copay per visit	100% after $10 copay per office visit – PCP//$20 Specialist copay per office visit	100% after $15 copay per office visit: $30 Specialist copay per visit
Well Care				
Routine Physical Exams	"Welcome to Medicare" One time only, within first 6 months of enrolling in Part B. 80% of approved amount, subject to $131 deductible.	Covered in full (when in accordance with GHC Well Adult & Well Child Schedule)	Medicare initial preventative physical exam covered in full, 100% after $10 copay for annual routine examination.	Medicare initial preventative physical exam covered in full, 100% after $15 copay for annual routine examination
Routine Mammography	80% of approved amount	Covered in full.	Covered in full.	Covered in full
Pap Smears	80% of approved amount	Covered in full.	Covered in full	Covered in full.
Mental Health				
Mental Health Inpatient and Outpatient	Inpatient – Same deductible & co-payments as shown under Hospitalization. Outpatient - 50% of approved amount for most outpatient mental health services, subject to $131deductible	Inpatient –. $100 copay per day to 3-day maximum per member per admission. GHC authorization required. Outpatient – Subject to Medicare guidelines. $15 copay per visit. GHC authorization required.	Inpatient: 100% after $200 copay, per admission Outpatient: 100% after $20 copay per Individual visit; 100% after $10 copay per Group office visit. .	Inpatient: 100% after $220 copay, 1-18 days: $0 copay thereafter Outpatient: 100% after $30 copay per Individual visit; 100% after $15 copay per Group office visit. .
	Psychiatric inpatient hospital care has a 190 day lifetime maximum		All referrals come through the Primary Care Physician (PCP)	

Home Health Care				
Part-time or intermittent skilled care or home health aide services	100% of approved amount for most services.	Covered for Medicare- certified skilled care through GHC Home Health Services, according to Medicare guidelines	0% copay	0% copay
Durable medical equipment and supplies	Varies dependent upon service.	Covered according to Medicare guidelines	20% coinsurance	20% coinsurance
Rehabilitation – Speech, Physical And Occupational Therapy				
Inpatient and outpatient services	80% for inpatient and outpatient services	Inpatient Services – Subject to $100 day copay to a 3-day maximum, per admission. Outpatient services covered subject to a $15 copay per visit.	Inpatient Services – 100% after $200 copay per admission. Outpatient services covered subject to $25 copay per visit.	Inpatient Services – Inpatient: 100% after $220 copay, 1-18 days: $0 copay thereafter Outpatient Services – 20% coinsurance
Prescription Drugs				
	Retiree selects a prescription Part D plan from a vendor, and pays a premium for the plan selected. To learn more about prescriptions plans available in your area, retiree can visit www.medicare.gov on the web or call 1-800-MEDICARE (1-800-633-4227), TTY users should call 1-877-486-2048	Purchased at GHC facility: Generic - $15 copay Brand - $30 copay 30-day supply for prescription or refill. Some exclusions apply. Copays do not apply toward out of pocket maximum.	**Retail:** 100% after $4 copay for Preferred Generic, 100% after $28 copay for Preferred Brand, 100% after $58 copay for non-Preferred Brand; 33% coinsurance for Preferred Specialty Drug. 30-day supply or one (1) Prescription Unit. **Mail Order:** 100% after $8 copay for Preferred Generic; 100% after $74 copay for Preferred Brand, 100% after $164 copay for non-Preferred Brand; 33% coinsurance for Preferred Specialty Drug.	**Retail:** 100% after $4 copay for Preferred Generic, 100% after $28 copay for Preferred Brand, 100% after $58 copay for non-Preferred Brand; 33% coinsurance for Preferred Specialty Drug. 30-day supply or one (1) Prescription Unit. **Mail Order:** 100% after $8 copay for Preferred Generic; 100% after $74 copay for Preferred Brand, 100% after $164 copay for non-Preferred Brand; 33% coinsurance for Preferred Specialty Drug.
Vision Care				
Exams	Not covered	Paid in full after $15 copay once every 12 months	100% after $20 copay	100% after $30 copay
Eyeglass Lenses & Frames	Not covered, with the exception of one pair of eyeglasses or contact lenses after each cataract surgery with an intraocular lens.	Standard lenses (including contact lenses) covered in full at UCR once every 24 months. One pair eyeglasses or contact lenses immediately following cataract surgery performed at GHC. Frames covered up to $100 once every 24 months.	Not covered	Not covered
Contact Lens Examination & Lenses		Paid in full once every 24 months in lieu of eyeglass benefit	Not covered	Not covered
Hearing Exams And Hearing Aids				
Exams	Routine Hearing Exam - Not covered	Covered in full after $15 copay per visit	$20 copay	$30 copay
Hearing Aids	Not covered	Routine hearing testing covered in full once every 24 months. Hearing aids covered up to $250, once every 24 months Must be purchased through GHC.	$300 every 24 months	$300 every 24 months
Premium per Month	Need to contact Medicare for Part A & B premium amounts as it varies per individual.	Medicare Advantage (w/Part D): $229.58 Medicare COB: $386.96*	$163.66	$79.00

*Group Health benefits provided are for members with Medicare A & B. Dependents without Medicare coverage have a different schedule of benefits.

*These rates apply to areas where Group Health does not have a Medicare Risk Contract. Medicare Advantage rates apply in all Western Washington counties and Spokane County.

NOTE: This is a brief summary of benefits. This is not a contract. For specific benefit information and exclusions, consult plan booklets.